Provider Insider

Alabama Medicaid Bulletin — **May 2004**

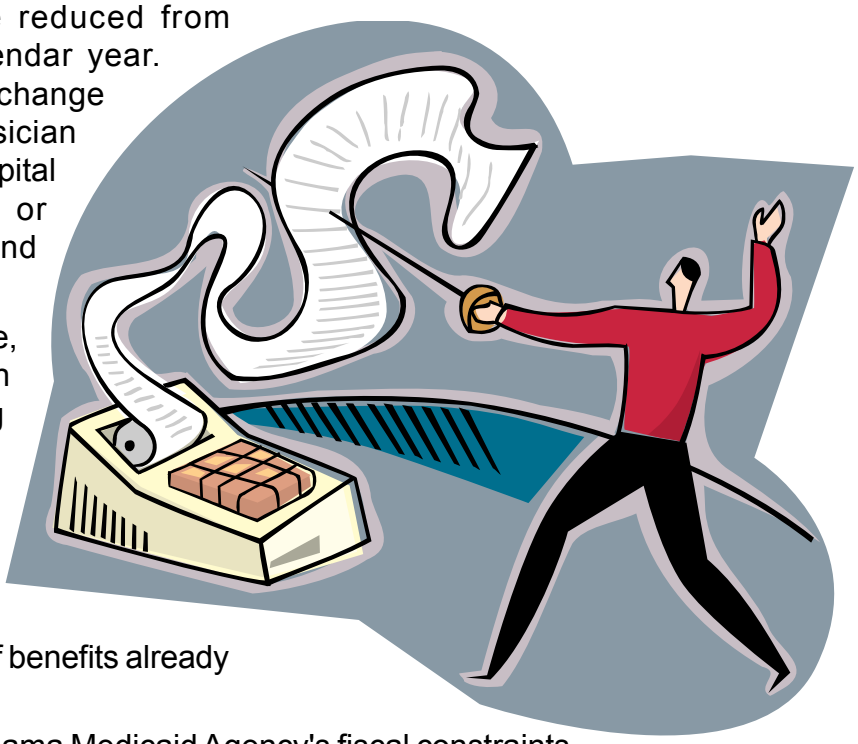
The checkwrite schedule is as follows:

05/07/04 05/21/04 06/04/04 06/18/04 07/09/04 07/23/04 08/06/04 8/20/04 09/03/04 09/10/04

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Announces Reduction of Office Visits

Effective for dates of service May 1, 2004 and thereafter, the number of physician office visits for each Alabama Medicaid recipient will be reduced from fourteen (14) to twelve (12) per calendar year. Recipients are being notified of this change through Recipient Notice 04-02. Physician office visits include visits in offices, hospital outpatient settings, nursing homes, or Federally Qualified Health Centers and Rural Health Clinics.



Additional physician visits are available, if medically necessary, for those children who have had an EPSDT screening (well child check-up) and referral.

Providers should refer to the Alabama Medicaid Provider Manual, Section 3.3.4, Appendix B, EMC Guidelines, and Appendix L, AVRS Quick Reference Guide for information about verification of benefits already paid by Alabama Medicaid.

This change is necessary due to the Alabama Medicaid Agency's fiscal constraints. Governor Bob Riley and Medicaid Commissioner Carol Herrmann have a special message to all providers on page 3 of this issue of the Provider Insider.

In This Issue…

Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Dental Procedure Code Correction

Procedure code D2950 is limited to recipients 15 years of age and older. This criteria was deleted from the provider manual in error and will be corrected in the July 2004 release. If you have questions, you may contact your EDS provider representative for more information.

Hospital Procedure Code not for Dental Providers

The procedure code D9420 is approved for hospital's facility fee only. This is not a covered procedure for dental providers. Please provide your prior authorization number to the hospitals so that they can bill for this service.

Retroactive Prior Authorization Request

The recipient must have been eligible on the date of service. The provider must submit the prior authorization request within 90 days of the retroactive eligibility award (issue date). For future dates, requests can be processed if eligible on the date the request is reviewed.

Attention Long Term Care Providers

The Alabama Medicaid Agency District Office must be notified of permanent discharges, absences and deaths for individuals certified by the District Office.

Procedures:

1. Long term care institutional providers must notify the appropriate District Office of permanent discharges, absences from the facility for 30 consecutive days, and deaths of residents.

2. Long term care waiver providers must notify the appropriate District Office of discharges, terminations, or deaths of waiver clients.

If you have questions or need any additional information, please call the LTC Provider/ Recipient Services Unit at or 1-800-362-1504.

New Providers Should Use Current Version of the Enrollment Application

To ensure we are providing the most up-to-date information, our enrollment applications are often being improved. For this reason, it is recommended that providers make certain they are completing and submitting the most recent version of the enrollment applications. Below is a list of the applications offered on our website and the date the application was last updated:

Provider Enrollment Application for Providers in Alabama and Bordering States February 2004

January and October 2003 Version is acceptable until September 30, 2004

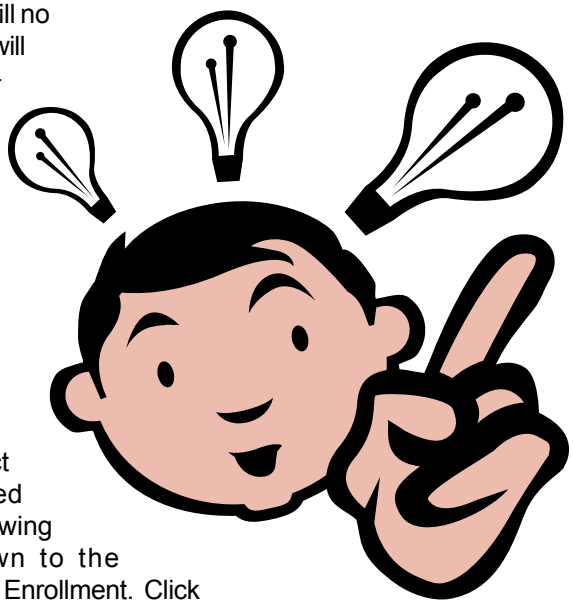
Provider Enrollment Application for Out-of-State QMB/DME Providers March 2004

Provider Enrollment Application for Out-of-State Institutional Providers March 2004

Provider Enrollment Application for Out-of-State Practitioners January 2003

Additional Location Enrollment Application-February 2004

Uniform Application Secondary Packet-March 2004
(The Uniform Application Secondary Packet is applicable for providers who have submitted a Blue Cross Blue Shield Universal Application to EDS for processing.)



Applications, which are older than the dates listed above will no longer be accepted and will be returned to the submitting office or person. To obtain the most current version of an application or to verify you have the most recent version of the application, we encourage providers to visit our website at *www.medicaid.state.al.us*. On the home page, select Providers, select the blue button labeled FORMS. On the following webpage, scroll down to the section labeled Provider Enrollment. Click on the enrollment application applicable to the enrolling provider.

By doing this, you can check the date of the packet applicable to the enrolling provider and print the application if necessary. If you do not have Internet access, you may call EDS' Provider Enrollment Department at 1-888-223-3630 or (334) 215-0111 to inquire about the applications.

NOTE: Any applications, which are not completed in black ink, will also be returned. Black ink is required due to the need to scan enrollment forms.

OFFICE OF THE GOVERNOR

BOB RILEY
GOVERNOR

STATE CAPITOL
MONTGOMERY, ALABAMA 36130

(334) 242-7100
FAX: (334) 242-0937

STATE OF ALABAMA

March 17, 2004

Greetings:

During this time of budgetary uncertainty, we want to express our deep and heartfelt appreciation for your willingness to provide vitally needed health care for more than 860,000 low-income Alabamians who depend on Medicaid. Without your involvement and commitment to these most needy of patients, many of these adults and children would miss out on the care and treatment essential to preventing more serious and costly health problems.

Without question, the challenge of how to fund the most basic health needs of low-income children and adults who qualify for Medicaid represents one of the most critical issues in the current legislative session. This issue, along with the dire financial circumstances facing our state, ensures that Medicaid will continue to be at the forefront of the debate among state leaders as we all struggle to make compassionate, but fiscally responsible decisions regarding our state's budgets.

We appreciate your support and input as we all work together to ensure that Alabama's low-income citizens have access to basic health care.

Sincerely,

Bob Riley
Governor of Alabama

Commissioner, Carol Herrmann
Alabama Medicaid Agency

Correct Modifiers for Ambulance Providers

Whenever a recipient is transported by ground ambulance from their residence to a site of transfer between modes of ambulance transport (ie: air transport) the modifier combination SI should be used. This would be from S (scene of accident or acute event) to I (site of transfer- e.g., airport or helicopter pad - between modes of ambulance transport). RI is not an approved modifier combination.

Attention Anesthesia Providers

The anesthesia procedure code and allowed minutes list will be moved from "Provider/Manual" to "Provider/Fee Schedule" and will be combined with the physician fee schedule in the future. To access this information, please visit our website at *www.medicaid.state.al.us*, select "Provider", then select "Fee Schedule".

Correct Billing for Avastin

The FDA approved Avastin (bevacizumab) as a "first line treatment for patients with metastatic colorectal cancer" on February 26, 2004. Alabama Medicaid will cover Avastin effective 2/26/04 under procedure code J9999 (not otherwise classified anti-neoplastic drugs). Please note that due to the FDA News information, Avastin will be covered only if it is given "as a combination treatment along with standard chemotherapy drugs for colon cancer," e.g., ironotecan, 5-fluorouracil (5FU) and leucovorin. J9999 must be billed on paper with the name of the drug, dosage and National Drug Number (NDC) (April 2004 Provider Manual Chapter 5, page 4). It is recommended that providers bill the other standard chemotherapy drug(s) being used with Avastin on the same claim form. If J9999 must also be used for the other chemotherapy drug, modifier 76 (repeat procedure by same physician), must be appended to the second line to prevent it from denying for a duplicative service. This must be done if J9999 is billed more than once on the same DOS, even if on different claims. HCPCS code S0116 (Bevacizumab 100mg) will be effective for DOS beginning July 1, 2004. Providers should begin to use this code for Avastin on this date, instead of J9999.

Information for DME Providers Concerning Incontinence Products

Effective April 1, 2004, incontinence products or disposable diapers will be prior authorized and covered using the following procedure codes:

A4521 - Adult-sized incontinence product, diaper, small

A4522 - Adult-sized incontinence product, diaper, medium

A4523 - Adult-sized incontinence product, diaper large

A4524 - Adult-sized incontinence product, diaper extra large

A4529 - Child-sized incontinence product, diaper small/medium

A4530 - Child-sized incontinence product, large

Upon furnishing durable medical/equipment supplies, the supplier should obtain a signature on any form he/she desires indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply item the supplier should verify the identify of the person signing for the items, i.e. relative, homehealth worker, neighbor.

When dispensing nebulizers (E0570) please adhere to Medicaid's established criteria. Remember that Medicaid recipients must meet at least one of the required medical diagnoses in the established criteria, and the additional medical documentation requested must be provided and kept in the recipient's file.

When dispensing durable medical equipment and supplies remember that medical documentation justifying the need for the services should be kept on file for 3 years.

Request for coverage of durable medical equipment must be received by EDS within thirty days after the equipment is dispensed. When the request is not received within the thirty day time frame for ongoing rental equipment (such as apnea monitors, pulse oximeters, oxygen, cpap machines, compressor, ventilators, bipap machines, compressors) the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from the dispensed date will be assigned an effective date based on actual date received by EDS if a recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. For answers to any questions or the need for any additional information, please call the LTC Provider/Recipient Services Unit at or 1-800-362-1504.

EDS Provider Representatives

G R O U P 1

North: Jenny Homler and Marilyn Ellis

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

jenny.homler
@eds.com
334-215-4142

marilyn.ellis
@eds.com
334-215-4159

South: Melanie Waybright and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology

melanie.waybright
@alxix.slg.eds.com
334-215-4155

denise.shepherd
@alxix.slg.eds.com
334-215-4132

CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services
(OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

stephanie.westhoff
@alxix.slg.eds.com
334-215-4199

tracy.ingram
@alxix.slg.eds.com
334-215-4158

Public Health
Elderly and Disabled Waiver
Home and Community
Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

ann.miller
@alxix.slg.eds.com
334-215-4156

shermeria.hardy
@alxix.slg.eds.com
334-215-4160

linda.hanks
@alxix.slg.eds.com
334-215-4130

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Prior Authorization Needed for Antihypertensive Agents

Effective April 1, 2004, the Alabama Medicaid Agency requires prior authorization (PA) for payment of non-preferred brand antihypertensive agents. The PA request form can be found on the Agency website at www.medicaid.state.al.us. Requests may be faxed, or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210
Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

PA requests failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must submit a written letter of medical justification along with the prior authorization form. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider alert should be directed to the Pharmacy Program at (800) 362-1504. Questions regarding prior authorization procedures should be directed to the HID help desk at (800) 748-0130.

Billing Procedures for Eye Care Providers

Eye care providers continue to misbill Medicaid for frames and lenses after they have routed work orders to Classic Optical for processing. The following policy procedures are being implemented effective April 1, 2004.

1. Classic will contact the ordering provider directly to determine if they inappropriately billed Medicaid.
2. The provider who billed erroneously will make an adjustment to the claim on-line (or hard copy using form ADJ-02, Medicaid Adjustment Request Form).
3. The erroneously billing provider, who submitted a request for an adjustment using a hard copy, will notify Classic after the adjustment has occurred
4. Classic will subsequently re-file their claim for payment.

Any unresolved Classic denials should continue to be forwarded to an appropriate Electronic Data Systems (EDS) provider representative for preliminary research. After the preliminary research is performed, it will be forwarded to the Agency for a final determination.

REMINDER

HOSPITAL OUTPATIENTS

Patients who stay overnight after outpatient surgery will be considered outpatients UNLESS the attending physician has written orders admitting the patient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

Referrals and the Patient 1st Program

Some concern regarding referrals has occurred as a result of the termination of the Patient 1st Program. This notice is for clarification purposes. There have been no program changes made to the EPSDT Program. Written referrals remain required for EPSDT and lock-in recipients. Referrals must be in writing on Form 362. EPSDT providers should sign the referral form and maintain the original in his/her medical record. Copies are to be forwarded to consultants to be maintained in their medical records.

EPSDT Periodic Rescreen List is Now Available

The Periodic Rescreen List is a monthly report mailed to EPSDT screening providers who performed the child's last EPSDT screening (well child check-up). The report is designed as a support tool to assist screening providers in scheduling timely screenings.

The report lists the recipient's number, name, address, date the next EPSDT screening is due, birthday, and the recipient's last comprehensive (head-to-toe) EPSDT screening date. A recipient's county code, obtained from a recipient's file, and the name of the provider who performed the last EPSDT screening will be added in the future.

Currently, the report is mailed to the billing provider's physical address. However, the report will be mailed to the group billing provider's payee address in the future. We will notify you through the Provider Insider when this will be implemented. If you have any questions, please call Brenda Vaughn at 334-242-5582.

What is a "Zero" Payment?

When Medicare reimburses more than Medicaid's allowed amount for qualified Medicare beneficiaries (QMB), Medicaid "zero" pays the claim and considers the claim as paid in full. In this situation, recipients may not be billed as the claim is considered paid in full.

www.medicaid.state.al.us

Alabama Medicaid

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

EPSDT Care Coordination Service

The Alabama Medicaid Agency initiated an EPSDT Care Coordination (CC) service available at no charge for private and public providers effective March 1, 2004. The goal is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The scopes of service are designed to support and assist your office staff. The scope of services include, but are not limited to, missed appointments, referral follow-up, children behind on immunizations, elevated blood lead levels, abnormal sickle cell and metabolic results, follow-up services for newborn hearing screenings, assist with transportation using the Non-Emergency Transportation (NET) program, identify children at greatest risk for targeted outreach, and identify children who have high utilization of emergency room visits.

EPSDT Care Coordinators are available by contacting your local county health department or by visiting our website at *www.medicaid.state.al.us*, select "General", then select "About". The title is "EPSDT Care Coordinators by County".

Locally Assigned Repeat Modifier Changed

As of January 1, 2004, locally assigned modifiers changed. Previously Alabama providers were advised to file multiple services with modifiers Y2-Y9 to avoid services being denied as duplicates. Since these modifiers are being eliminated, we are revising instructions for filing multiple services that are performed on the same day. Modifier 76 has replaced modifiers Y2-Y9. Modifier 76 should only be used for lab, radiology, surgical, and injectable drug procedures. Modifier 76 should only be used once with the appropriate number of units. The first line item must be submitted with the applicable procedure code and only one unit of service. The second line item must be submitted with the same procedure code with modifier 76 and the appropriate number of units that were performed that day.

Example:	Date of Service	Place	Procedure	Number of Services
	02/04/03 – 02/04/03	11	21600	1
	02/04/03 – 02/04/03	11	21600-76	2

Providers should bill using the correct number of units instead of multiple details. If a provider feels that additional units are needed, please write a letter of justification with supporting medical documentation to:

Alabama Medicaid Agency
Attn: Physician Services
P. O. Box 5624
Montgomery, AL 36103-5624

EDS
Alabama Medicaid Bulletin
Post Office Box 244032
Montgomery, AL 36124-4032

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